WAC 284-43-210 ((~~Network reporting requirement and~~)) Access plan. Beginning January 1, 1999, health carriers shall file with the commissioner an access plan meeting the requirements of this subchapter for each of the ((~~managed care~~)) health plans that the carrier offers in this state. The health carrier shall make the access plans available on its business premises and shall provide them to any interested party upon request. The carrier shall prepare an access plan prior to offering a new ((~~managed care~~)) health plan, and shall update an existing access plan whenever it makes any material change to an existing ((~~managed care~~)) health plan. Upon written request and following written approval by the agency, a carrier may file an access plan that applies to more than one health plan in accordance with any conditions or instructions contained in the written approval. The access plan shall contain at least the following:

(1) A description of the health carrier's network of providers and facilities by license or certification type and by geographic location;

(2) The following provision is a restatement of a statutory requirement found in RCW 48.43.095 (1)(c) included here for ease of reference: "A full description of the procedures to be followed by an enrollee for consulting a provider other than the primary care provider and whether the enrollee's primary care provider, the carrier's medical director, or another entity must authorize the referral";

(3) A description of the health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to provide covered services that meet the health care needs of populations that enroll in managed care plans;

(4) A description of the health carrier's efforts to address the needs of covered persons with limited English proficiency and literacy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(5) A description of the health carrier's methods for assessing the health care needs of covered persons and their satisfaction with services;

(6) A description of the health carrier's method of informing covered persons of the plan's services and features, including but not limited to, the plan's grievance procedures, its process for covered persons choosing and changing providers, and its procedures for providing and approving emergency and specialty care including the following restated statutory requirements found in RCW 48.43.095 (1)(e), (f), and (i) included here for ease of reference: "Procedures, if any, that an enrollee must first follow for obtaining prior authorization for health care services . . ., and . . . description of any reimbursement or payment arrangements, including, but not limited to, capitation provisions, fee-for-service provisions, and health care delivery efficiency provisions, between a carrier and a provider . . ., and . . . Descriptions and justifications for provider compensation programs, including any incentives or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists";

(7) A description of the health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty providers, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(8) A description of the health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers and facilities, or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transferred to other providers in a timely manner; ((~~and~~))

(9) A description of the health carrier's strategy for integrating public health goals with health services offered to covered persons under the managed care plans of the health carrier, including a description of the health carrier's good faith efforts to initiate or maintain communication with public health agencies((~~.~~));

(10) A description of the health carrier's methods for assessing the health status of its covered persons including a description of how the carrier incorporates findings of local public health community assessments;

(11) A description of the health carrier's policy and procedures relating to health information privacy including information concerning any rights the covered person has to restrict access to health information and to obtain access to their own health information.

With respect to the above required elements of an access plan, each carrier shall provide sufficient information to

allow the commissioner and consumers to determine the extent of a carrier's efforts. For example, if a carrier makes little or no effort to coordinate health plan services with public health goals, then the carrier shall report that it does not coordinate services with public health goals.

AMENDATORY SECTION (Amending Order R 97-3, filed 1/22/98, effective 2/22/98)